

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 3 9

2. STATE:

Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

December 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.185

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ -0-

b. FFY 2003 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Please see attached listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Please see attached listing

10. SUBJECT OF AMENDMENT:

The Arkansas Title XIX State Plan has been amended to move ventilator equipment from
the prosthetic devices category to Item 22. Respiratory care services category.

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Ray Hanley

14. TITLE:

Director, Division of Medical Services

15. DATE SUBMITTED:

December 3, 2001

16. RETURN TO:

Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437Attention: Binnie Alberius
Slot XXXX S295**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

December 10, 2001

18. DATE APPROVED:

December 20, 2001

19. EFFECTIVE DATE OF APPROVED MATERIAL:

December 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

D. Wade Murphy Acting for Calvin G. Cline

21. TYPED NAME:

Calvin G. Cline

22. TITLE: Associate Regional Administrator

Division of Medicaid and State Operations

23. REMARKS:

**ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2001-039**

**8. Number of the Plan
Section or Attachment**

Attachment 3.1-A, Page 8g

None

Attachment 3.1-B, Page 5aa

Attachment 3.1-B, Page 8aa

Attachment 4.19-B, Page 1j

Attachment 4.19-B, Page 4c

Attachment 4.19-B, Page 7i

**9. Number of the Superseded Plan
Section or Attachment**

Attachment 3.1-A, Page 8g
Approved 01-05-90, TN 89-50

Attachment 3.1-A, Page 5bb
Approved 1-21-93, TN 92-42

Attachment 3.1-B, Page 5aa
Approved 07-24-97, TN 97-08

Attachment 3.1-B, Page 8aa.
Approved 07-12-94, TN 94-12

Attachment 4.19-B, Page 1j
Approved 01-17-95, TN 94-26

Attachment 4.19-B, Page 4c
Approved 03-29-89, TN 89-08

Attachment 4.19-B, Page 7i
Approved 04-20-01, TN 01-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 8g

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: December 1, 2001

CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with Section 1920 of the Act).

Services are limited to the same benefit limits as other pregnancy-related services, i.e., outpatient hospital, physician, lab and X-ray, etc.

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).

1. Ventilator Equipment (i.e., ventilator, suction pump, oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, ventilator supplies and hospital bed) including 24-hour availability of respiratory therapy and equipment maintenance, with prior authorization.

PERSEDES: TN- 89-50

STATE	<u>Arkansas</u>
DATE REC'D	<u>12-10-2001</u>
DATE APP'D	<u>12-20-2001</u>
DATE EFF.	<u>12-01-2001</u>
HCFA 179	<u>Ark-01-39</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 5aa

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: December 1, 2001

MEDICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

(5) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.

(6) Medical Supplies

Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home (Home does not include a long term care facility.) Supplies are limited to a maximum reimbursement of \$250.00 per month, per recipient. As medical supplies are also provided to recipients through the Home Health Program, the maximum reimbursement of \$250.00 per month may be provided through the Prosthetics Program, the Home Health Program or a combination of the two. However, a recipient may not receive more than \$250.00 in supplies whether received through either of the two programs or a combination of the two unless an extension has been granted. Extensions will be considered for recipients under age 21 in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.

SUPERSEDES TN- 97-08

STATE	Arkansas
DATE RECD	12-10-2001
DATE APPVD	12-20-2001
DATE EFF	12-01-2001
HCFA 178	AK-01-39

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 8aa

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: December 1, 2001

MEDICALLY NEEDY

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).
1. Ventilator Equipment (i.e., ventilator, suction pump, oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, ventilator supplies and hospital bed) including 24-hour availability of respiratory therapy and equipment maintenance, with prior authorization.

SUPERSEDES TN- 9412

STATE <u>Arkansas</u>	A
DATE REC'D <u>12-10-2001</u>	
DATE APP'D <u>12-20-2001</u>	
DATE EFF <u>12-01-2001</u>	
HCFA 179 <u>AR-01-39</u>	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: December 1, 2001

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(8) The following services that are not otherwise covered under the Arkansas State Plan will be reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral (Continued):

b. Orthotic Appliances and Prosthetic Devices

The reimbursement methodology for orthotic appliances and prosthetic devices will be based on amount billed not to exceed the Title XIX maximum. The Title XIX maximum is based on the Medicare Fiscal Year 1990 DME fee schedule.

c. Respiratory Care Services

Respiratory Therapy Services for Ventilator-Dependent

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1990 survey of three Arkansas durable medical companies who employ respiratory therapists. The rate was established by using the median rate obtained by the DME companies.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rate was decreased by 20%.

SUPERSEDES TN- 94-26

STATE	Arkansas
DATE RECD	12-10-2001
DATE APP'D	12-20-2001
DATE EFF	12-01-2001
HCFA 179	AR-01-39

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-B
Page 4c

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: December 1, 2001

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

RESERVED

SUPERSEDES IN 84-08

STATE	Arkansas
DATE REC'D	12-10-2001
DATE APP'D	12-20-2001
DATE EFF	12-01-2001
HCFA 179	ARL-01-39

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-B
Page 7i

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised:

December 1, 2001

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act.)

Reimbursement for these services is described in Attachment 4.19-B, e.g. outpatient hospital, physician services, etc.

22. Respiratory care services (in accordance with section 1920(e)(9)(A) through (C) of the Act).
1. See reimbursement methodology **for respiratory therapy services for ventilator-dependent recipients under age 21** on Attachment 4.19-B, Page 1j.
 2. Ventilator equipment - Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum is based on the following:

- (a) The positive pressure ventilator and accessories are based on the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for new equipment and 75% of the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for used equipment.
- (b) The suction pump is based on Medicare's rate in effect in August 1987 for new equipment. Used equipment is based on 75% of Medicare's rate.
- (c) The negative pressure ventilator and accessories are based on the manufacturer's price plus 10% for the maintenance, delivery, set up, emergency call, 24/hr/day, 7 day/week availability.
- (d) The oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, hospital bed and nebulizer are based on the DME Fiscal Year 1981 Medicare median.
- (e) The ventilator supplies are based on the manufacturer's price.

The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

SUPERSEDES: TNL 01-01

STATE	Arkansas
DATE REC'D	12-10-2001
DATE APPRO'D	12-20-2001
DATE REC'D	12-01-2001
HCFA 179	AR-01-39

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**DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services**

Calvin G. Cline

Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 827
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0270

December 20, 2001

Our Reference: SPA-AR-01-39

Mr. Ray Hanley, Director
Division of Medical Services – Slot 1103
Arkansas Department of Human Services
Post Office Box 1437
Little Rock, Arkansas 72203-1437

Dear Mr. Hanley:

We have enclosed a copy of HCFA-179, Transmittal Number 01-39, dated December 3, 2001. This amendment moves ventilator equipment from the prosthetics devices category to the respiratory care services category.

We have approved the amendment for incorporation into the official Arkansas State Plan effective December 1, 2001. If you have any questions, please call Bill Brooks at (214) 767-4461.

Sincerely,

Diane Wade Murphy, Acting
for Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosure

cc: Elliott Weisman, CMSO

